neoadjuvant treatment and are, in fact, more extensively involved after preoperative treatment as determined by the operative or pathology report, code the farthest extension.

Example: Patient has needle biopsy-proven prostate cancer with no mention of involved lymph nodes on physical examination. He receives Lupron while deciding whether to undergo a radical prostatectomy. At the time of surgery, a laparoscopic pelvic lymph node biopsy is reported to show metastases. Code CS Lymph Nodes as 10 because the preoperative treatment (Lupron) had no effect on the lymph nodes.

f. Lymph nodes should be considered as not involved for primaries with in situ extension and coded as 00 (None). In situ by definition means non-invasive. If there is evidence of nodal involvement associated with a tumor described as in situ, it would indicate that an area of invasion was missed and the primary tumor is not an in situ lesion, so lymph nodes can be coded as appropriate for the case.

g. If there is direct extension of the primary tumor into a regional lymph node, record the involved lymph node in this field.

2. For solid tumors, the terms “fixed” or “matted” and “mass in the hilum, mediastinum, retroperitoneum, and/or mesentery” (with no specific information as to tissue involved) are considered involvement of lymph nodes.

a. Any other terms, such as “palpable”, “enlarged”, “visible swelling”, “shotty” or “lymphadenopathy” should be ignored unless there is a statement of involvement by the clinician.

EXCEPTION: *The terms* adenopathy, enlargement, *and* mass in the hilum or mediastinum *should be coded as involvement for lung primaries only.*

b. For lymphomas, any positive mention of lymph nodes indicates involvement of those lymph nodes.

c. Regional nodes are not palpable for inaccessible sites such (but not limited to) as **bladder, kidney, prostate, esophagus, stomach, lung, liver, corpus uteri, ovary, etc.** The best information on regional lymph node involvement will be on imaging studies or the surgeon’s description at the time of exploratory or definitive surgery. If regional lymph nodes for these sites are not mentioned in these reports, they are presumed to be clinically negative and should be coded to 00.

d. The terms “homolateral”, ipsilateral”, and “same side” are used interchangeably.

e. Any unidentified nodes included with the resected primary site specimen are to be coded as Regional Lymph Nodes, NOS. Coding of NOS categories for lymph nodes should be used only after an exhaustive search for more specific information.

f. Size of the involved regional nodes can be found on the pathology report and should be